Method: An 8-item electronic questionnaire was distributed to 32 medical and 72 nursing schools. Medical and nursing analyses were conducted separately, and only final-year responses were included.
Results: 1,459 medical students from 22 universities, and 1,879 nursing students from 31 universities completed the survey. 37.8% of medical and 52.3% of nursing students received teaching on the checklist, whilst 6.3% of medical and 4.0% of nursing students were formally examined on it. 72.9% of medical and 66.1% of nursing students understood its purpose. There was a significant relationship between receiving training and understanding in both cohorts ($p < 0.0001$). Understanding varied according to inclusion in the Time Out. Medical students were more likely to be included than nurses.
Conclusion: Undergraduate surgical safety checklist training does not meet the WHO standards, with wide variations in experience. Knowledge of perioperative patient checks, and participation in safety protocols, are important skills that should be taught at undergraduate level.

http://dx.doi.org/10.1016/j.ijsu.2016.08.088

1278: DOES SPLIT-SITE WORKING AFFECT TRAINING?

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Aim: Service rationalisation in the NHS has lead to clinical teams covering multiple hospital sites. We evaluate referral trends before and after the centralisation of Urology services at our institution and its impact on junior doctor training.
Methods: A prospective analysis of all referrals over 3 months was performed before and after the reconfiguration of our department to a single site. Training requirements were outlined as per the intercollegiate surgical curriculum programme (ISCP) syllabus.
Results: Before: Of 256 referrals, 36% were for advice, 41% required admission and 23% required intervention. The commonest pathologies encountered were stone disease, urinary tract obstruction and haematuria.
After: Of a total of 222 referrals, 40% were for advice, 38% were for admission and 22% for intervention. The commonest pathologies requiring intervention were for urinary tract obstruction, stone disease and testicular pain.
In both time periods, the referral pattern and operative spread did meet the ISCP requirements.
Conclusions: Service rationalisation reduced the overall number of referrals to urology, without alternating their nature. Surgical opportunities before and after the move correlated with the national requirements for Urologists in training.

http://dx.doi.org/10.1016/j.ijsu.2016.08.089

0804: INTRAVENOUS FLUID THERAPY IN THE ADULT SURGICAL PATIENT

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Aims: The prescribing of intravenous (IV) fluid is a mainstay of care for patients across the country. We aimed to analyse the adherence of our unit to the NICE guidelines. We also sought to assess the understanding of IV fluid therapy among Foundation Year (FY) doctors.
Methods: This was a closed loop audit. Data was retrospectively collected for patients in a 95-bed General Surgical unit who had been receiving IV fluid for over 24 h. FY doctors were approached to complete a questionnaire about IV fluids. The intervention was in two parts: a one-hour teaching session followed by the NICE elearning module on IV fluids. Data collection was then repeated 3 months later.
Results: Of the FY1s surveyed, 47% knew the values for sodium in 1 L of Hartmann's fluid. IV fluid prescriptions contained excess fluid (patients were on average 1.5 L in excess) with excess sodium (mean of 130 mmol), excess chloride and insufficient potassium. After intervention, the average patient was only 500 ml positive and sodium excess had reduced to 45 mmol.
Conclusions: IV fluid knowledge is poor and this is reflected in prescriptions. This simple and reproducible intervention produced a marked improvement in knowledge and prescriptions and will ultimately improve patient safety.

http://dx.doi.org/10.1016/j.ijsu.2016.08.090

0937: CAN NEWLY APPOINTED CONSULTANTS ACHIEVE NATIONAL STANDARDS IN COLORECTAL CANCER SURGERY?

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All primary colorectal cancer resections performed in the first 15 months of practice of three newly appointed consultant surgeons were prospectively audited and their outcome data compared to National Bowel Cancer Audit Standards. Demographics and outcomes measures were collected from October 2014 - December 2015.
58 patients underwent primary resection. 37.9% of patients were ≥75 years old. 24% of resections were performed as emergency or expedited cases. Compared to national data, patients had a higher elective ASA grade (37.9% ≥ ASA 3 vs 21.5%). 53.4% underwent laparoscopic, or hand-assisted laparoscopic resection despite more advanced pathological staging (86% ≥ pT3 vs 74.9%). 20.7% had metastases at diagnosis compared with 8.9% nationally.
82.8% of resections went to HDU or ITU post-operatively compared to 32.5% nationally. Median length of stay was 7 days, 30-day mortality was 3.4%, despite a mean CR possum score of 5%. 85% of resections were R0 and mean lymph node yield was 28.
Newly appointed consultants can achieve national standards of care in colorectal cancer resections from the start of their practice, even with a patient cohort exhibiting more advanced disease at presentation and higher peri-operative morbidity than the national average.

http://dx.doi.org/10.1016/j.ijsu.2016.08.091

1362: ENDOSCOPIC AND MINIMAL INVASIVE SURGERIES FOR SELLAR AND PARASELLAR TUMORS: CADAVERIC DATA

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Aim: Aim of this study is to assess assumed advantage of the pure endoscopic to endoscopic assisted or Microscopic supraorbital key hole approach. The idea is to measure visibility and accessibility to avoid the surgical complications.
Method: We will perform eight dissections on eight cadaver heads. This dissections integrated an operating microscope, endoscope, and neuronavigation. Comparison was made between visibility and accessability of sellar and parasellar region in both approaches.
Results: Our measurements of the formalin fixed heads including each side; the mean ± SD from the bone margin to anterior communicating artery = 68.56 ± 6.00, to ipsilateral internal carotid artery = 74.24 ± 7.76, to contralateral internal carotid artery = 82.85 ± 7.50, to basilar bifurcation = 86.16 ± 5.11, to optic chiasma = 75.11 ± 5.82, to ipsilateral anterior clinoidal process = 65.69 ± 6.62, to ipsilateral posterior clinoidal process = 74.3 ± 7.29, to ipsilateral optic canal = 63.73 ± 6.13.
Conclusion: Using endoscope alone during conducting the keyhole approach is better/or no advantage over Using the endoscope as an assistance tool. Our recommendations are to use the introduced